

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06183 06183

1. DECEASED NAME (Type or Print)		First GENE	Middle EDWARD	Last GREENE	20. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year April 5, 1968	21. Month Day Year April 5, 1968	22. HOUR 2 A.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH Jan. 19, 1942		6. AGE (in years last birthday) 26 yrs	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Somerset		23. DATE PRONOUNCED DEAD Month Day Year April 5, 1968	
10. CITY OR TOWN OF DEATH near Shelltown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pocomoke River			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Deckhand		12b. KIND OF BUSINESS OR INDUSTRY Plywood Corp.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia		13b. COUNTY Gloucester		13c. CITY OR TOWN Hayes	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. # 1		
14. FATHER'S NAME First Clarence		Middle Edward	Last Greene	15. MOTHER'S MAIDEN NAME First Norma	Middle Ethel	Last Coates		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Virginia A. Greene - same as 13 abce		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning DUE TO, OR AS A CONSEQUENCE OF 832X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 851X None								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
MEDICAL CERTIFICATION		21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2:00 P.M. 4/5 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell overboard from tugboat			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Pocomoke River		21f. LOCATION Street or R.F.D. No. City or Town near Shelltown-Somerset-Maryland		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>C. G. Rawley.</i>		EXAMINER'S NAME (Type) C. G. Rawley, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Crisfield, Md.		22b. DATE SIGNED April 5, 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 7, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Rosewell Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Ordinary-Gloucester-Virginia			
24. FUNERAL DIRECTOR Bradshaw & Sons - Crisfield, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE APR 9 - 1968		25b. REGISTRAR'S SIGNATURE <i>James J. Rawley</i>		

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.E. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

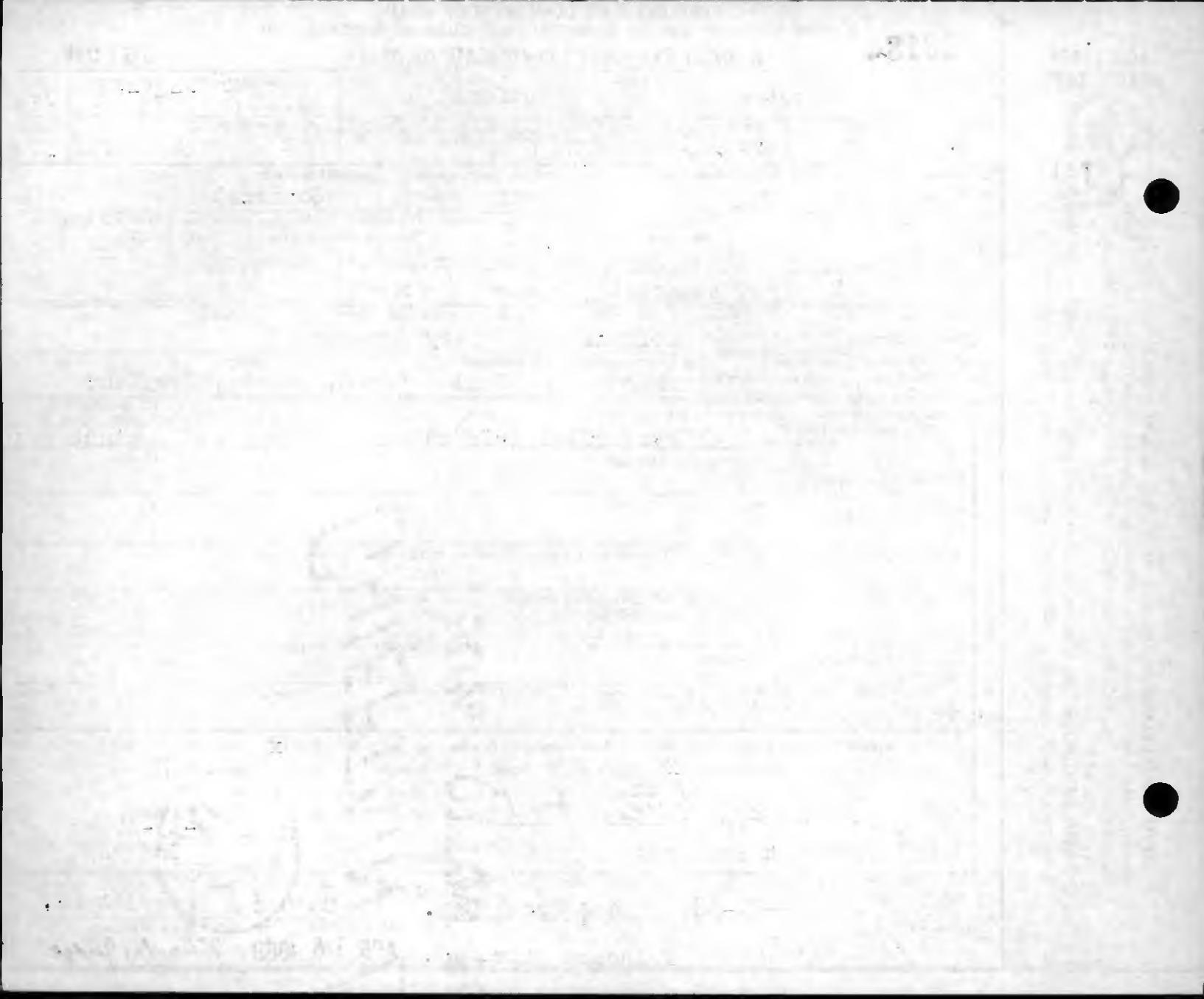
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06184

06184

1. DECEASED-NAME (Type or Print)		First Ernest	Middle Hoffman	Lost		20. DATE KNOWN OF ESTI- DEATH MATED		Month 4-13-68 19	Year 1968	2b. HOUR 7P M		
3. SEX m	4. RACE W	5. DATE OF BIRTH April 1900	6. AGE (in years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day 14 Year 1968			2d. HOUR 1P M	
7a. BIRTHPLACE (State or foreign country) Somerset		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Somerset						
10. CITY OR TOWN OF DEATH Wenona		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Somerset		13c. CITY OR TOWN Wenona		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME Prettyman		Middle Hoffman	15. MOTHER'S MAIDEN NAME Mary Cooksey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) unknown		17. INFORMANT Carl Hoffman, Wenona, Maryland		ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. { b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>Everett Sutter MD</u>		EXAMINER'S NAME (Type) Everett Sutter MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-15-68		ADDRESS (Street, city, town, or county) Somerset		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-17-68		23c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cem.		23d. LOCATION (City or Town) Chance		(County) Somerset		(State) Md.		
24. FUNERAL DIRECTOR <u>Kathy Webster</u>		ADDRESS Princess Anne, Md		25a. REC'D BY REGISTRAR APR 18 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



FOR STATE
HEALTH DEPT.

06185

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06191



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with family PMR. Page 5 may be retained for your files.

Health prior to burial, cremation, or removal,



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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Chief Medical Examiner's Office along with family PMR. Page 5 may be retained for your files.

1. DECEASED NAME (Type or Print)	First Hilton	Middle	Last Kellam, III	2a. DATE KNOWN OF ESTI. DEATH MATED	Month Day Year Apr. 17 1968	2b. HOUR 6:00 a.m.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS DAYS HOURS MIN.	
Male	Negro	Feb. 19, 1968	1 28			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED DIVORCED	9. COUNTY OF DEATH	2c. DATE PRONOUNCED DEAD Month Day Year Apr. 17 1968		
Maryland	USA	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED	Somerset	10. CITY OR TOWN OF DEATH Westover		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. 1, Box 147			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Rt. 1, Box 147		
Md.	Somerset	Westover				
14. FATHER'S NAME	First Hilton	Middle	Last Kellam, Jr.	15. MOTHER'S MAIDEN NAME First Betty	Middle Lou	Last Barber
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Betty Lou Kellam	ADDRESS Westover, Md.			
No	None					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 486X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last. DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hrs.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 493X						
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19c. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE 2	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) C. G. Rawley				22b. DATE SIGNED Apr. 18, 1968 Crisfield, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/19/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Frank Town Cem., Exmore	23d. LOCATION (City or Town) (County) Exmore	25a. REC'D BY REGISTRAR DATE MAY 17 1968	25b. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Anthony E. Ward	Cemetery, Md.					
VR A15ME (5) 10M REV. 1/68						

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W. G. L. D. A. M. A.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. (Then please remove carbon paper. Pages 1-3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. DECEASED NAME (Type or print)			First Belma	Middle Melton	Last Lewis	2a. DATE OF DEATH Month April	Day 20	Year 1968	2b. HOUR M
3. SEX female		4. RACE white		5. DATE OF BIRTH July 12, 1910		6. AGE (In years last birthday) 57		IF UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE (State or foreign country) Alabama		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Somerset			
10. CITY OR TOWN OF DEATH Princess Anne			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) S. Somerset Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Somerset		13c. CITY OR TOWN Princess Anne		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER S. Somerset Ave.	
14. FATHER'S NAME First Tilden			Middle Melton	Lost	15. MOTHER'S MAIDEN NAME First Millie		Middle Dunnan	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT A.C. Lewis, Princess Anne, Md.			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109			MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF ATHEROSCLEROTIC C.V.D.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201			DUE TO, OR AS A CONSEQUENCE OF (b) 7 YEARS			(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 4/20/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Princess Anne, Md.		21f. LOCATION Street or R.F.D. No. Princess Anne, Md.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Nov 19, 66 to 4-22-68 , that (I) (we) last saw the deceased alive on 1-22-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Geo M Dunn MD					22c. DATE SIGNED 4-22-68				
22d. PHYSICIAN'S NAME (Type) George M. Dunn					22e. ADDRESS Princess Anne, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/22/68		23c. NAME OF CEMETERY OR CREMATORIAL Beechwood			23d. LOCATION (City or Town) Princess Anne, Somerset, Md.		(County) (State)
24. FUNERAL DIRECTOR James M. Dunn, Princess Anne, Md.		ADDRESS			25a. REC'D BY REGISTRAR APR 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		
VR A15 (4) 30M REV. 1/68					DATE				

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH
Item #17 film G DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
06187 Item 13 Film G 400 5/6/68

36193

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First Annie	Middle E	Last Miles	2a. DATE OF DEATH Month 4	Day 22	Year 68	2b. HOUR M				
3. SEX Female	4. RACE Colored	5. DATE OF BIRTH 4/24/1890			6. AGE (In years last birthday) 77	YRS. 7	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN 0		
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Somerset		Md.				
10. CITY OR TOWN OF DEATH Princess Anne, Md	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) None			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None			12b. KIND OF BUSINESS OR INDUSTRY None				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) Maryland	13b. COUNTY Somerset	13c. CITY OR TOWN Pr. Anne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. 3. Box 213							
14. FATHER'S NAME First George Parson	Middle	Last	15. MOTHER'S MAIDEN NAME First Mary Fooks	Middle	Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 433-0	17. INFORMANT Pr. Anne	Address Joshua Miles, Westover, Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 332X											
19a. DATE OF OPERATION 332X	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eldon G. Markman	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED April 25 '68							
22d. PHYSICIAN'S NAME (Type) Eldon G. Markman	22e. ADDRESS Princess Anne, Maryland										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/28/68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope	23d. LOCATION (City or Town) Princess Anne, Maryland	(County) 	(State) 						
24. FUNERAL DIRECTOR William H. James Jr.	ADDRESS Princess Anne, Maryland	25a. REC'D BY REGISTRAR APR 30 1968	25b. REGISTRAR'S SIGNATURE Charles Judge								
VR A15 (4) 3DM REV. 1/68											

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CC-13

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First ANTOINETTE	Middle	Last MUELLER	2a. DATE OF DEATH Month Day Year April 22 1968	2b. HOUR 11:10 AM		
3. SEX Female		4. RACE White		S. DATE OF BIRTH March 21, 1886	6. AGE (in years last birthday) 82 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Somerset			
10. CITY OR TOWN OF DEATH Marion Station		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY At Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE New York		13b. COUNTY Suffolk	13c. CITY OR TOWN N. Babylon	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 36 Frankie Lane			
14. FATHER'S NAME Christian		Middle Hebbel	Last	15. MOTHER'S MAIDEN NAME First Eliza		Middle	Last Gall	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 125-34-3322		17. INFORMANT Mrs. George Anger - same as 10, 11, 9 above		Address		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Acute Dil of heart</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>4179</u></p> <p>(b) <u>Arterio-sclerotic heart Cond.</u> DUE TO, OR AS A CONSEQUENCE OF last.</p> <p>(c) <u>Chronic Myocarditis C. dil Nephritis</u></p>								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>acute - yrs - ..</u>								
<p>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</p> <p><u>General Arterio fibrosis -</u></p>								
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, name medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1, 1968</u> , to <u>Apr. 14, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Apr. 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>George C. Coulbourn M.D.</u>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>4-23-68</u>		
22d. PHYSICIAN'S NAME (Type) George C. Coulbourn, M.D.		22e. ADDRESS Marion Station, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 26, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Cypress Hills Cemetery		23d. LOCATION (City or Town) (County) Cypress Hills-Queens-N.Y. (State)			
24. FUNERAL DIRECTOR Bradshaw & Sons — Crisfield, Md.		ADDRESS Bradshaw & Sons — Crisfield, Md.	25a. REC'D BY REGISTRAR DATE APR 25 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

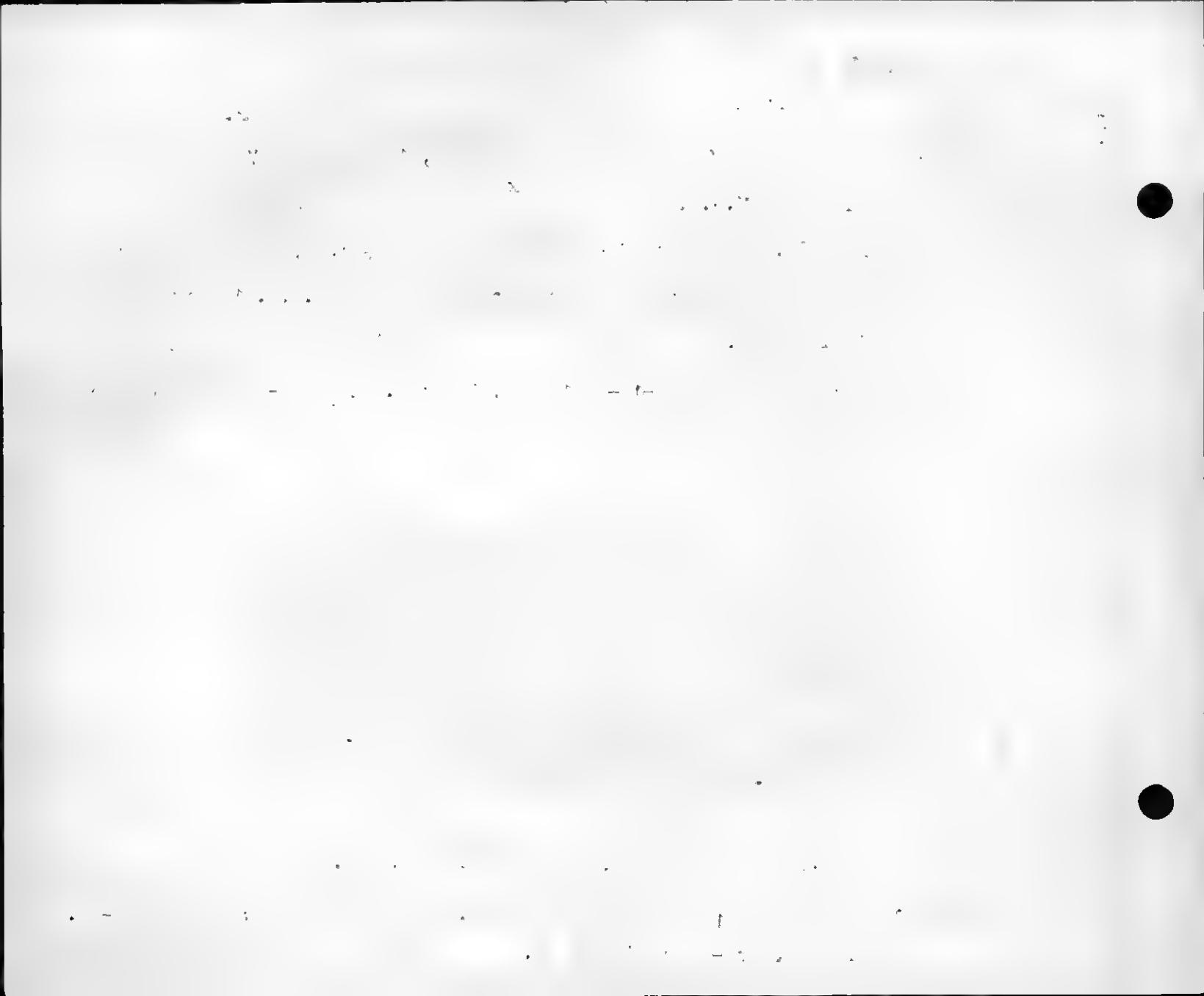
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 Film G400 L94548 Rev. 4-65

CERTIFICATE OF DEATH

4-65-4-389

1. DECEASED NAME (Type or print)	First Sherwood	Middle	Last Northam	2a. DATE OF DEATH Month Apr. 23 Year 68	2b. HOUR 6 PM	
3. SEX Male	4. RACE White	S. DATE OF BIRTH June 9, 1894-1893	6. AGE (in years last birthday) 76 yrs	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Somerset	Md.		
10. CITY OR TOWN OF DEATH Crisfield, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital giving address) McCready Memorial	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machine	12b. KIND OF BUSINESS OR INDUSTRY Engineering			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Somerset	13c. CITY OR TOWN Crisfield	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. 1 Box 93		
14. FATHER'S NAME First William	Middle W.	Last Northam	15. MOTHER'S MAIDEN NAME Glive	Middle	Last Ayres	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes	16b. SOCIAL SECURITY NO I & II	17. INFORMANT Mrs. Helen R. Northam - same as 13 abc	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-7-68 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			Approximate interval between onset and death years.			
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
MEDICAL CERTIFICATION		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 4-7-68 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE C. G. Rawley		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED 4/24/68	
22d. PHYSICIAN'S NAME (Type) C. G. Rawley, M.D.		22e. ADDRESS Crisfield, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE April 26, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Modest Town Cemetery	23d. LOCATION (City or Town) Modest Town- Accomack-Va.	(County)	(State)	
24. FUNERAL DIRECTOR Fradshaw & Sons - Crisfield, Md.	ADDRESS Fradshaw & Sons - Crisfield, Md.	25a. REC'D BY REGISTRAR DATE MAY 6 1968	25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 30M REV 1/68						



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary; please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files. 5 may be retained for your files.

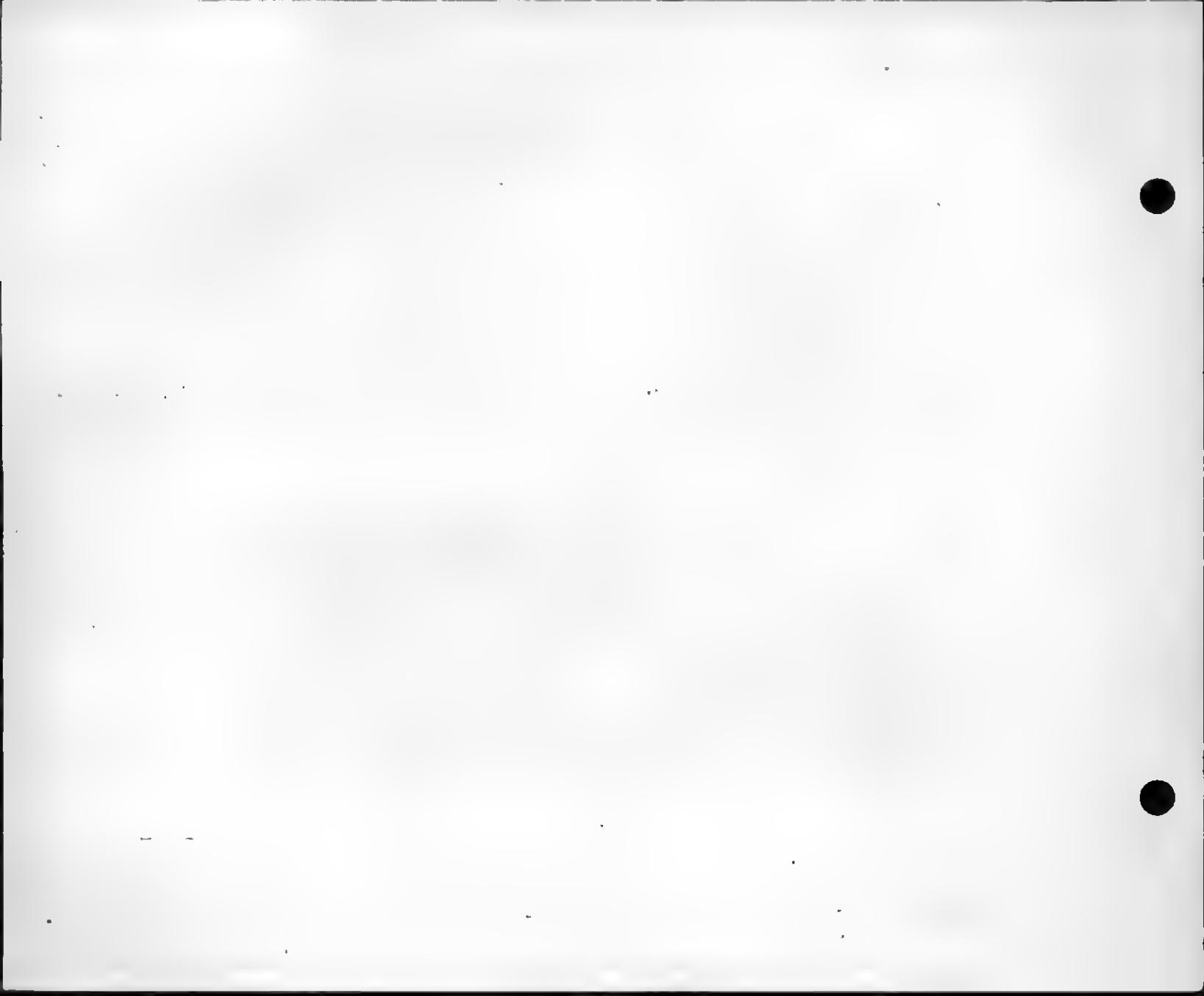
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16196

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF EST. DEATH MATED	Month	Day	Year	2b. HOUR
		Charles H Wesley Price			4	13	68	17:30	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. IF UNDER 1 YEAR MONTHS	8. IF UNDER 24 MRS. DAYS	9. HOURS	10. MIN.	2d. HOUR	
Male	W	3-31-1890	78	YRS.				7:40	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
UK Somerset		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Somerset			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Chance					Waterman				
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS	13e. STREET AND NUMBER			
Md		Somerset		Chance	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
		F Charles W Price			Julia Jones				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		unknown		Wife (Elizabeth Price)		Chance, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Congestive failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4127 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Coronary arteriosclerosis						minutes years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4001									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d. AUTOPSY?	
19c. MEDICAL CERTIFICATION								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Everett Sutter</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4-15-68		
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
23a. BUR. A. CREMATION, REMOVAL (Specify)		23b. DATE 4-16-68		23c. NAME OF CEMETERY OR CREMATORIALy Rock Creek, Chance		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR		ADDRESS LeRoy Webster		25a. REC'D BY REG STRR Princess Anne		25b. REGISTRAR'S SIGNATURE APR 19 1968 Charles Judge			

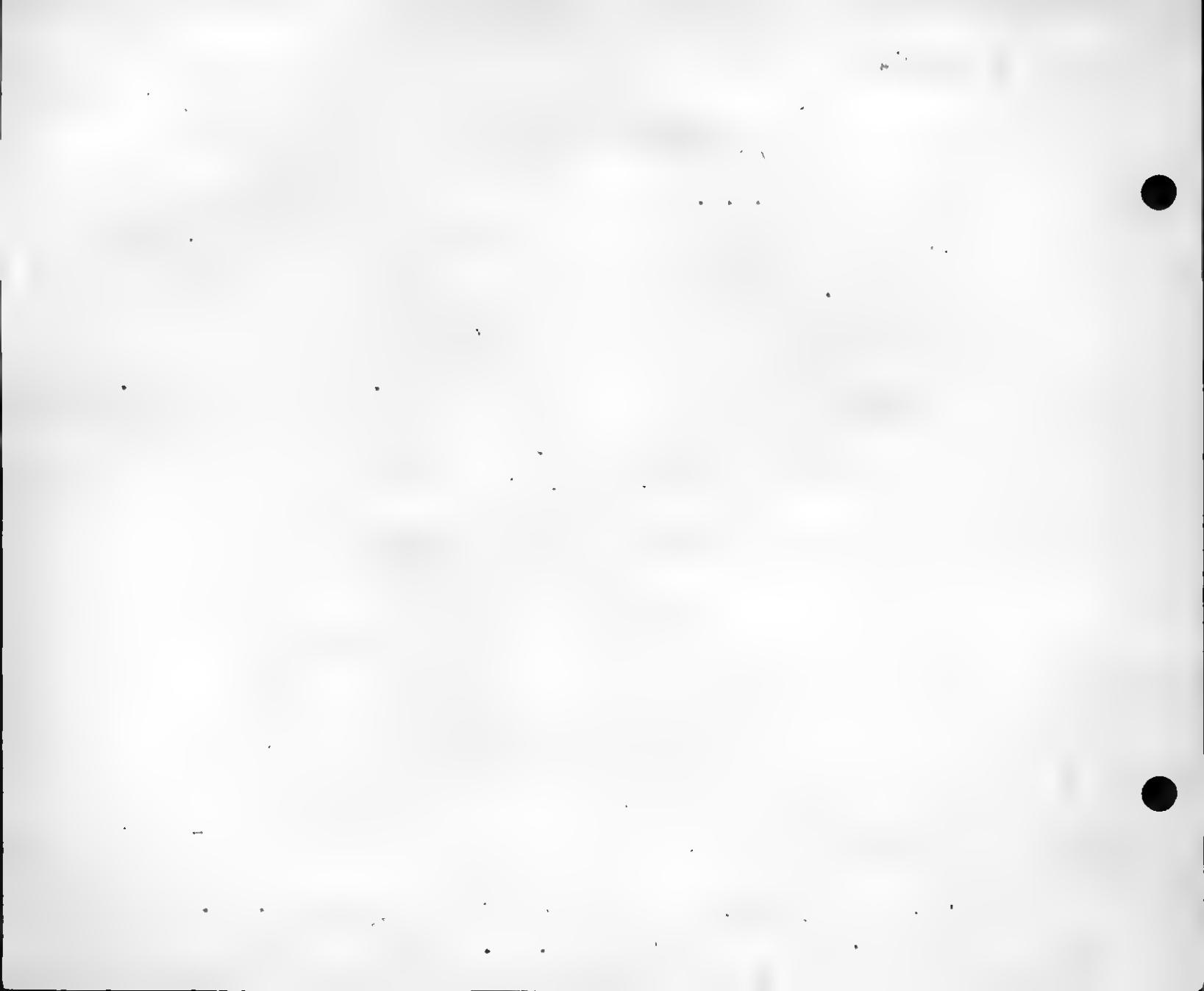


FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5 F32

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)	First GUY	Middle	Last ROSS	2a DATE KNOWN OF ESTI- DEATH MATED 4/26/68	Month Day Year 4/26 68	2b HOUR M
3 SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 2/17/1904	6. AGE (In years at birthday) 64 yrs.	F UNDER 1 YEAR MONTHS 64	IF UNDER 24 HRS HOURS MIN	2d HOUR M
7a BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH SOMERSET	2c DATE PRONOUNCED DEAD Month 19	Doy Year 19	2d HOUR M
10 CITY OR TOWN OF DEATH ORIOLE	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED WATERMAN & CARPENTER	12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.	13b CITY OR TOWN SOMERSET	13c CITY OR TOWN ORIOLE	13d NSIDE CTY LIM TS?	13e STREET AND NUMBER YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME ROBERT ROSS	First	Middle	Last	15 MOTHER'S MAIDEN NAME REBECCA DAVIS	Middle	Last
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT MRS ANNA M. ROSS	ADDRESS ORIOLE, MD.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost (b) Coronary arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min to s years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Everett Sutter</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	22b. DATE SIGNED 4-29-68	ADDRESS (Street, city, town, or county) ORIOLE, MD.
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b DATE 4/29/1968	23c NAME OF CEMETERY OR CREMATORIAL ORIOLE CEMETERY	23d LOCATION (City or Town) ORIOLE, MD.	(County)	(State)	
24 FUNERAL DIRECTOR LEVIN R. WILSON	ADDRESS PRINCESS ANNE, MD.	25a REC'D BY REGISTRAR MAY 01 1968	25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

06192

06198

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trait permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)		First	Middle	Lost	20. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> APRIL 22 1968	2b. HOUR 2040 AM
HAROLD T. WAGNER						
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH NOV. 9, 1884	6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month APRIL Day 22 Year 1968	2d. HOUR 8 AM
7a. BIRTHPLACE (State or foreign country) SOMERSET CO.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH SOMERSET CO.	
10. CITY OR TOWN OF DEATH MANOKIN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) AT HOME			12a. USUAL OCCUPATION (Kind of work done or present or working if deceased) RETIRED FARMER	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY SOMERSET		13c. CITY OR TOWN MANOKIN, MD.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First JAKE		Middle WAGNER	Lost	15. MOTHER'S MAIDEN NAME First HARRIETT BOZMAN	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT MRS. AMANDA WAGNER ADDRESS MANOKIN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF minutes Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary arteriosclerosis years lost. (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. MEDICAL CERTIFICATION EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>Everett Sutter</i>		EXAMINER'S NAME (Type) Everett Sutter MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)	22b. DATE SIGNED 4-24-68	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 4/25/1968	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS ST. ANDREW CEMETERY	23d. LOCATION (City or Town) (County) (State) PRINCESS ANNE, MD.		
24. FUNERAL DIRECTOR LEWIN R. WILSON		25a. RECD BY REGISTRAR DATE APR 26 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First JOHN	Middle COULBOURN	Last WILSON, JR.	2d. DATE OF DEATH Month April	Day 3	Year 1968	2b. HOUR 3:30a.m.				
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 17, 1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS 00	IF UNDER 24 HRS. HOURS 19	IF UNDER 24 HRS. MIN. 1		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH Somerset		Md.				
7c. WIDOWED <input type="checkbox"/>		8 DIVORCED <input type="checkbox"/>										
10. CITY OR TOWN OF DEATH Marion Station			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) White's Road			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) poultryman & farmer			12b. KIND OF BUSINESS OR INDUSTRY Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN Somerset			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER White's Road			
14. FATHER'S NAME First John			Middle Coulbourn			15. MOTHER'S MAIDEN NAME First Hattie			Middle Williams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 212-16-1610			17. INFORMANT Mrs. Mary B. Wilson, same as 13 abce			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction - Arteriosclerotic heart</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4120			DUE TO, OR AS A CONSEQUENCE OF C. diff. Myphitis - C. Myocarditis - Cond.									
			(b) <i>C. diff. Myphitis - C. Myocarditis -</i>						year			
			(c) <i>General Arteriosclerosis -</i>						"			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 442X												
19a. DATE OF OPERATION 442X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1966 , to Apr. 3, 1968 , that (I) (we) last saw the deceased alive on Apr. 2-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>George C. Coulbourn, M.D.</i>		DEGREE ATTENDING PHYS.			22c. DATE SIGNED 4-5-68		MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (Type) George C. Coulbourn, M.D.		22e. ADDRESS Marion Station, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 5, 1968		23c. NAME OF CEMETERY OR CREMATORY Sunnyridge Cemetery			23d. LOCATION (City or Town) Crisfield-Somerset-Md.		(County)		(State)	
24. FUNERAL DIRECTOR Bradshaw & Sons - Crisfield, Md.		ADDRESS Bradshaw & Sons - Crisfield, Md.			25a. REC'D BY REGISTRAR APR 9 - 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

